POC accepted over telephone 3/31/06 BA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295020	A. BUILDING _____ B. WING _____	C 03/09/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRYMAN REHABILITATION CENTER	2045 SILVERADA BLVD. RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of five (5) complaint investigations conducted at your facility beginning on February 25, 2005. The investigations were finalized on March 9, 2005. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00007247 alleged that the facility neglected a resident, lost the resident's personal belongings, and failed to adequately document the condition of a resident. The issue of neglect was not substantiated. The loss of the resident's belongings was substantiated. No deficiency was cited based on the facility's actions. The failure to adequately document the resident's condition was not substantiated. Complaint #NV00007253 was an incident reported by the facility of an altercation between two (2)residents. The altercation was substantiated. No deficiency was cited based on the facility's actions. Complaint #NV00007255 was an incident reported by the facility of a resident fall. The fall was substantiated. No deficiency was cited based on the facility's actions. Complaint #NV00007257 was an incident reported by the facility that a resident did not	F 000		

RECEIVED
MAR 30 2005
BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jane C. Madurski	Associate Administrator	3/29/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 return from an outside appointment. The incident was substantiated. No deficiency was cited based on the facility's actions. Complaint #NV00007258 was a fall by a resident reported by the facility. The fall was substantiated. No deficiency related to the reported fall was cited based on the facility's actions. Deficiencies related to other issues were found and cited. See F 157, F 225, F 281, and F 324.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or	F 157		

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F 157	Continued From page 2 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to notify the resident's physician or responsible party of a fall. (Resident #6) Findings include: Resident #6: The resident was admitted to the facility on 12/21/04 with the diagnoses that included diabetes, dementia, peripheral vascular disease, and congestive heart failure. A review of the resident's care plan revealed an entry dated 2/21/05 that read, "found on floor." Further review of the record failed to reveal evidence of documentation of a fall with or without injury or evidence that the resident's physician or responsible party was notified of a fall. The findings were confirmed in an interview with the DON on 2/25/05 at 10:10 AM.	F 157		
F 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		

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F 225	Continued From page 3 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to investigate and report the results of the investigation of an unwitnessed fall. (Resident #6) Findings include: Resident #6: The resident was admitted to the	F 225		

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F 225	Continued From page 4 facility on 12/21/04 with the diagnoses that included diabetes, dementia, peripheral vascular disease, and congestive heart failure. A review of the resident's care plan revealed an entry dated 2/21/05 that read, "found on floor." Further review of the record failed to reveal evidence of documentation of a fall with or without injury in the nurse's notes. An interview with the DON on 2/25/05 at 10:10 AM failed to reveal evidence either in the documentation or in the staff's verbal reports of a fall. The DON stated that she did not receive an incident report regarding a fall on 2/21/05. The nurse on duty was not available at the time of the interview. On 3/2/05 at 2:30 PM, a telephone interview was conducted with the DON. The DON stated that she had spoken with the nurse who was on duty. The nurse had advised the DON that the fall was not documented in the nurse's notes and that she did not complete an incident report. Because the fall had not been reported to the facility's administration, the incident was not investigated and the results of the investigation were not reported to the Bureau.	F 225		
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to document, assess, and report that a resident was found on the floor in accordance with professional standards of quality. (Resident #6)	F 281		

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F 281	Continued From page 5 Findings include: Resident #6: The resident was admitted to the facility on 12/21/04 with the diagnoses that included diabetes, dementia, peripheral vascular disease, and congestive heart failure. During the admission assessment the facility determined that the resident was a high fall risk. A care plan was developed and safety devices were implemented. A review of the resident's care plan revealed an entry dated 2/21/05 that read, "found on floor." Further review of the record failed to reveal evidence of documentation of a fall with or without injury in the nurse's notes. The documentation failed to reveal evidence that the nurse notified the resident's physician or responsible party of the fall. An interview with the DON on 2/25/05 at 10:10 AM failed to reveal evidence either in the documentation or in the verbal reports of a fall. The DON stated that she did not receive an incident report regarding a fall on 2/21/05. The nurse on duty was not available at the time of the interview. On 3/2/05 at 2:30 PM, a telephone interview was conducted with the DON. The DON stated that she had spoken with the nurse who was on duty. The nurse had advised the DON that the fall was not documented in the nurse's notes and that she did not complete an incident report.	F 281		
F 324 SS=D	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 324		

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F 324	Continued From page 6 Based on observation, interview, and record review it was determined that the facility failed to implement a safety device as ordered for a resident with a history of numerous falls. (Resident #6) Findings include: Resident #6: The resident was admitted to the facility on 12/21/04 with the diagnoses that included diabetes, dementia, peripheral vascular disease, and congestive heart failure. During the admission assessment the facility determined that the resident was a high fall risk. A care plan was developed and safety devices were implemented. The most recent orders for safety devices included a back release seat belt and a TAB's alarm when in bed and the wheelchair. The resident was observed at 9:55 AM on 2/25/05. The back release belt was in place. A TAB's monitor was not seen. The DON was advised of the observation and she stated that she thought that the TAB's monitor had been discontinued. She was shown the physician's order in the record.	F 324		

Due to Length of Plan of Corrections, Submission is being made outside of the Statement of Deficiencies.

June C. Madurski Associate Administrator 3/29/05

June C. Madurski Associate Administrator 03/29/05

This Plan of Correction (POC) is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or State Regulations or failed to follow any applicable standard of care.
Re: F157 483.10 (b)(11) Notification of Rights and Services.
Berryman Rehabilitation Center makes every attempt to keep resident family/concerned parties informed on resident's current status. To this goal, BRC strives to ensure that the resident's physician and/or responsible party is notified on any fall within the facility. The complaint investigated and being addressed within this POC is that based on interview and facility document review the surveyor determined that the facility failed to provide documentation stating notification of physician or responsible party of a fall.

Immediate Correction was instituted in the form of:

- Meeting with Director of Nursing and Nurse on Duty on date in question upon receipt of Statement of Deficiencies 3/24/05 via telephone call regarding incident and question and 1:1 education for nurse on Duty on date of question provided by D.O.N. on 3/24/05

Identification of other residents having the potential to be affected will be made through the following measures (including corrective actions)

- All current residents who were under the care of the nurse on duty on date in question 2/21/05 have potential to be affected due to surveyor findings of failure to document compliance with facility procedures and standards.
- As such, corrective measures addressing nurse on duty as stated above.

Measures and Systemic Changes put in place include:

- One on One education of Nurse on Duty 2/21/05 by D.O.N.
- Fall procedure quizzes Monday through Friday during Associate Admin. Rounds with prizes for nurses with correct answers X 2 weeks. (See attached quiz sheet). Beginning 3/29/05

Corrective action will be monitored by:

- Increased compliance with procedure and reduction of mistakes in incident investigation as noted by reviews of incident reports by D.O.N. and Associate Administrator.
- Nursing ability to provide correct answers during daily quizzes.

Re: F225 483.13 (c)(1) (ii) Notification of Rights and Services.
Berryman Rehabilitation Center has policy and procedures in place to prevent employment of individuals determined unfit for service. To this goal, BRC investigates and reports the findings of the investigation of all unwitnessed falls. The complaint investigated and being addressed within this POC is that based on interview and facility document review the surveyor determined that the facility failed to provide documentation stating investigation and report to appropriate agency of a fall.

Immediate Correction was instituted in the form of:

- Meeting with Director of Nursing and Nurse on Duty on date in question upon receipt of Statement of Deficiencies 3/24/05 via telephone call regarding incident and question and 1:1 education for nurse on Duty on date of question provided by D.O.N. on 3/24/05

Identification of other residents having the potential to be affected will be made through the following measures (including corrective actions)

- All current residents who were under the care of the nurse on duty on date in question 2/21/05 have potential to be affected due to surveyor findings of failure to document compliance with facility procedures and standards.
- As such, corrective measures addressing nurse on duty as stated above.

Measures and Systemic Changes put in place include:

- One on One education of Nurse on Duty 2/21/05 by D.O.N.
- Fall procedure quizzes Monday through Friday during Associate Admin. Rounds with prizes for nurses with correct answers X 2 weeks. (See attached quiz sheet). Beginning 3/29/05
- Posting by Associate Administrator on 4/1/05 the Legal, Financial and Physical Ramifications of Nursing Facility falls.

Corrective action will be monitored by:

- Increased compliance with procedure and reduction of mistakes in incident investigation as noted by reviews of incident reports by D.O.N. and Associate Administrator.
- Nursing ability to provide correct answers during daily quizzes.

Re: F281 483.20 (k)(2) (i) Resident Assessment
Berryman Rehabilitation Center provides resident assessment services to meet professional standards of quality. To meet the standards the facility has in place Policy and Procedure regarding Resident Assessment related to falls.
The complaint investigated and being addressed within this POC is that based on interview and facility document review the surveyor determined that the facility failed to provide documentation of assessment and report of a resident found on the floor.

Immediate Correction was instituted in the form of:

- Meeting with Director of Nursing and Nurse on Duty on date in question upon receipt of Statement of Deficiencies 3/24/05 via telephone call regarding incident and question and 1:1 education for nurse on Duty on date of question provided by D.O.N. on 3/24/05

Identification of other residents having the potential to be affected will be made through the following measures (including corrective actions)

- All current residents who were under the care of the nurse on duty on date in question 2/21/05 have potential to be affected due to surveyor findings of failure to document compliance with facility procedures and standards.
- As such, corrective measures addressing nurse on duty as stated above.

Measures and Systemic Changes put in place include:

- One on One education of Nurse on Duty 2/21/05 by D.O.N.
- Fall procedure quizzes Monday through Friday during Associate Admin. Rounds with prizes for nurses with correct answers X 2 weeks. (See attached quiz sheet). Beginning 3/29/05
- Posting by Associate Administrator on 4/1/05 the Legal, Financial and Physical Ramifications of Nursing Facility falls.

Corrective action will be monitored by:

- Increased compliance with procedure and reduction of mistakes in incident investigation as noted by reviews of incident reports by D.O.N. and Associate Administrator.
- Nursing ability to provide correct answers during daily quizzes.

Re: F324 483.25 (h)(2) Quality of Care
Berryman Rehabilitation Center strives to meet all standards related to Quality of Care when providing resident services. As part of meeting the standard, BRC has in place several systems to provide supervision and devices to prevent accidents.
The complaint investigated and being addressed within this POC is that based on observation, interview and facility document review the surveyor determined that the facility failed to implement an assistive device as ordered.

Immediate Correction was instituted in the form of:

- Review of Physician orders of resident by D.O.N. and appropriate safety devices in place as ordered by Physician. 2/25/05(Device has since been discontinued per physician order.)

Identification of other residents having the potential to be affected will be made through the following measures (including corrective actions)

- All current residents assessed as fall risks and determined to require assistive devices are potentially affected by this practice.

Measures and Systemic Changes put in place include:

- Communication to C.N.A. staff regarding devices to be used placed on census sheets daily by Charge Nurse. 3/25/05
- Posting by Associate Administrator on 4/1/05 the Legal, Financial and Physical Ramifications of Nursing Facility falls.

Corrective action will be monitored by:

- Decreased falls due to increased staff compliance with safety devices as ordered by M.D.
- Devices noted to be in place as observed by D.O.N. during daily rounds.